MEMORANDUM

Texas Department of Human Services * Long Term Care/Policy

TO: Home and Community Support Services Agencies (HCSSA) Program Administrators
LTC-R Regional Directors
State Office Section/Unit Managers

FROM: Marc Gold, Director
Long Term Care Policy
State Office MC: W-519

SUBJECT: Regional Survey & Certification Letter #00-22

DATE: October 16, 2000

The attached RS&C Letter is being provided to you for information purposes and should be shared with all professional staff.

- RS&C Letter No. 00-22 -- Home Health Agencies-Reciprocal Agreements Between States and Supervision of Branches; Call Mary Jo Grassmuck, R.N., Home and Community Support Services Agency, at (512) 438-2100.

If you have any questions, please direct inquiries to the individuals or sections listed above.

- Original Signature on File -

Marc Gold

Attachment

Department of Health & Human Services
Health Care Financing Administration
Division of Medicaid and State Operations, Region VI

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September 14, 2000

REGIONAL SURVEY AND CERTIFICATION LETTER NO. 00-22

TO: All State Survey Agencies (Action)
All Title XIX Single State Agencies (Information)

SUBJECT: Home Health Agencies-Reciprocal Agreements Between States and Supervision of Branches

The purpose of this letter is to provide clarification and guidance related to reciprocal agreements between States for home health agencies (HHAs) with branch locations in more than one State and how supervision should occur for these branches.

State Survey Agency Reciprocal Agreements

The State Operations Manual (SOM) provides for a process that requires the provider to notify the State survey agency (SA) of its intent to expand locations. The SA reviews the request and makes a recommendation to the Regional Office (RO). The RO applies HCFA policy guidelines on a case-by-case basis and after a review, with or without a survey, the RO renders a final determination. We believe this general model, with some clarification, will better assure the development of SA reciprocal agreements to provide HCFA with the capacity to determine if the expanded HHA locations across State lines comply with the CoPs.

A review of the SOM at sections 3324 and 2184 (attached) state that the RO is responsible for approving Medicare provider expansion locations. In the case of an HHA, which provides, or proposes to provide, services across State lines, whether through its own personnel, a branch, or a subunit, each respective SA must be aware of, and be prepared to fulfill the necessary survey and certification responsibilities required to approve or disapprove the expanded location. In addition, each SA must verify that applicable personnel licensure and other requirements are met. The State in which the HHA parent is located has jurisdiction for certifying to the RO that the Federal requirements are met. The States involved in the expansion location request should have a reciprocal written agreement for all new HHA requests for operating across State lines.

These agreements should ensure that all SA functions relevant to the HHA parent, branch or subunit are identified (e.g., initial certification, recertification, and complaint investigations). The agreement should include the responsibilities and contacts for each SA involved. Each SA is responsible for the costs associated with their respective reciprocal agreement activities. If, at any time, the SAs are unable to resolve the relevant oversight issues, the RO should not approve the request for expansion. A more detailed discussion of this process follows.

Guidance in the SOM states that Medicare providers are required to notify HCFA of proposed service area expansions when adding a location. In the case of an HHA, this means a branch or a subunit. The provider is required to submit to HCFA the appropriate information necessary to make a determination on whether to approve or disapprove the proposed branch. When notifying HCFA, the provider is responsible for the completion and submission of the appropriate documentation (e.g., Form HCFA-855,) and any additional information necessary to allow the RO

to complete the determination process. Section 3124 of the SOM entitled *Addition of Sites to an Existing Provider* states:

"It is inherent in the provider certification process that a provider provides notification to HCFA of its proposal to expand its service area by adding a branch, satellite or extension location. The Medicare statute and applicable regulations are implicit that the proposed expanded service area meet the Conditions of Participation the same as the primary location that has signed the provider agreement or that has been assigned a provider number or both. In the absence of notification, HCFA has no way of determining whether the requirements critical to health and safety are met at the expanded location."

As provided for at Section 3224 of the SOM, upon receipt of a provider's expansion request, which may be received via the SA, the RO reviews the supporting documentation, makes a determination, and notifies the appropriate parties. Before making the determination the RO considers the following:

1. Whether the proposal meets the Medicare statutory and regulatory requirements:

2. If the proposal complies with State and local laws related to the particular type of provider/supplier; and

3. Whether Medicare reimbursement is affected by the proposal and if additional input from the fiscal intermediary or other HCFA component is necessary.

Based upon review of the supporting documentation and the development of satisfactory reciprocal agreement, the RO could make the following determinations related to a request for a branch expansion of a parent HHA:

- **Approval of the expansion request**

  The information included in the expansion request proposal is sufficient and thorough enough to allow the RO to make a determination. Although legal authority exists for conducting a survey, a survey may not be necessary based upon the information submitted by the provider.

- **Additional action required prior to final determination**

  The expansion request information provided by the provider is inconclusive. The provider is notified that a survey will be necessary to determine if the proposed location meets the definition of a branch, and if so, to ensure its compliance with the CoPs. The provider should be notified that it should not bill Medicare for services provided by the expanded location until the survey is conducted and a final determination is made by the RO.

- **Disapproval of the expansion request**

  Based upon the expansion request and a review of the relevant information, the RO determines that the proposed location does not meet the definition of a branch. However, the provider may apply for this location to be approved as a subunit. In addition, if the SAs are unable to enter into a satisfactory reciprocal agreement, the RO should deny the expansion request because of inadequate means of assuring critical health and safety requirements.

For all determinations, the RO will notify the provider and other appropriate parties (e.g., fiscal intermediary) of their decision.

HHA Branch Supervision

Under current statute and regulations, the only HHA locations recognized are approved parents, branches or subunits. Supervision at all approved HHA locations is critical to the provision of quality care for patients. The regulations do require the branch to be close enough to the parent to share supervision, administration and services on a daily basis.

"Supervision requires, unless otherwise specified in the regulations, that a qualified person be physically present during the provision of services by any individual who does not meet the qualifications specified at 42 CFR 484.4. While we support the effective use of telephones, pagers, facsimiles, or other devices, we do not believe that these are a substitute for or eliminate the requirement for the physical presence of the supervisor."

In addition, for purposes of determining branch compliance with the CoPs, the RO must review any relevant State issues and recommendations. These issues may be quite complex if an HHA operates across State lines. We encourage you to work with us and to develop reciprocal agreements that provide HCFA with the capacity of determine compliance with the health and safety standards.

If you have any questions, please contact Jann Caldwell, of my staff, at (214) 767-4401.

Sincerely,

- Signature on file -

Molly Crawshaw, Chief
Survey and Certification Operations Branch
Division of Medicaid and State Operations

Enclosure

Subunit - The parent agency's group of professional personnel may also serve as the subunit's group of professional personnel. The parent agency and subunit's policy statements and minutes of group meetings must include specific references to issues addressed in the subunit('s) delivery of home health services. The subunit may establish its own group of professional personnel or it may form a subcommittee of the parent HHA's group which deals specifically with the subunits's policies and procedures.

Clinical Records 42 CFR Part 484.48

Branch - Should retain the clinical records for its patients, since the branch site is where the professionals providing the services are located. Duplicate records need not be maintained at the parent agency, but must be made available to the surveyor upon request.

Subunit - Maintains clinical records on all its patients.

2184. OPERATION OF HHA ACROSS STATE LINES

When an HHA provides services across State lines, it must be certified in the State in which its parent office is based, and its personnel must be qualified in all States in which such personnel provide services. The involved States should have a reciprocal agreement, either verbal or written, permitting the HHA to provide services in this manner.

When an agency provides services across State lines, whether through its own personnel, a branch, or subunit, each respective SA must be aware of and approve the action. Each SA must verify that applicable personnel licensure and other requirements are met.

In most circumstances, the provision of services across State lines is appropriate. Areas in which community services, such as hospitals, public transportation, and personnel services are shared on both sides of State boundaries are most likely to generate an extension of services.

A branch office may also be physically located in a neighboring State if it is near enough to the parent agency to share administration, supervision, and services, and if the SAs responsible for certification in each State approve the operation.

Subunits of an HHA may be physically located in more than one State. A separate certification is made by the SA where each subunit is located.

2186. HEALTH FACILITY-BASED HHAs

An HHA located in a hospital, SNF, hospice, or rehabilitation facility is not required to be totally independent of the institution. Administrative and fiscal controls may be exercised over the HHA. However, the HHA's policies, personnel files, and clinical records must be separate and identifiable. Time records must be maintained for all personnel who provide home health services regardless of whether they are part-time or full-time. The HHA's concurrent use of personnel employed by a hospital, SNF, hospice, or rehabilitation facility is acceptable provided the HHA's operating hours are definite and not arbitrarily subject to the operation of the other institution, and provided the other institution's operation does not interfere with the HHA's maintaining compliance with the CoPs.

An HHA's services must be supervised by an employee of the HHA. If members of the institution's governing body serve the HHA as the group of professional personnel, minutes must reflect meetings of this group. Clinical records may be maintained in the record room or department. However, the clinical records must contain information pertinent only to the delivery of home health services, and should be readily available for either claims review or review by the SA.

When a request is received, the RO must determine whether there is a shortage of HHAs in the area. If there is an existing HHA furnishing services in the RHC area, the SA contacts the HHA for a statement of its ability or inability to adequately furnish nursing services in the area. In addition, the SA obtains information from the local or State health planning organization. The SA transmits the request and all pertinent documentation to the RO. The SA does not approve the visiting nurse services at this point.

If the RO determines that there is not a shortage of home health services for the area, authority to furnish visiting nursing services to homebound patients will be denied, and the RHC will be expected to refer its homebound patients to the HHA serving the area. The SA will receive a copy of the RO determination notice.

For purposes of this development, a "homebound individual" is one permanently or temporarily confined to his/her place of residence because of a medical or health condition. The individual may leave the place of residence infrequently and still be considered homebound. However, an individual in a hospital or long term care facility is not "homebound" for purposes of visiting nurse services.

If the RO determines that there is a shortage of home health services, it will request that the SA evaluate the qualifications of RHC personnel who are responsible for delivery of nursing services.

The SA completes the applicable sections of the Rural Health Clinic Survey Report (Form HCFA-30) for visiting nurse services and a written plan of care. The SA reviews records (plans of care and other appropriate records) to verify that such services are provided to homebound individuals and are furnished under written plans of care developed and signed by the supervising physician, nurse practitioner, physician assistant, or nurse midwife and reviewed by the supervising physician at least every 60 days. If the service has recently been implemented, it may be necessary for the SA to follow-up later to determine that the 60-day requirement is being observed.

When the above development has been completed and evaluated, the SA completes a supplementary certification for the visiting nurse service.

C. ESRD Facilities-Expansion In Number of Approved Stations.--Follow the procedure in §2274. (Also see Exhibit 27.)

3224. ADDITION OF SITES TO AN EXISTING PROVIDER

It is inherent in the provider certification process that a provider provide notification to HCFA of its proposal to expand its service area by adding a branch, satellite or extension location. The Medicare statute and applicable regulations are implicit that the proposed expanded service area meet the Conditions of Participtionthe same as the primary location that has signed the provider agreement or that has been assigned a provider number or both. In the absence of notification, HCFA has no way of determining whether the requirements critical to health and safety are met at the expanded location. For example, a hospice's request for satellite location may be denied because it cannot demonstrate how the hospice will assume administrtive and supervisory responsibility for the services provided at the expansion site. Moreover, there is no basis for a provider to bill Medicare for services provided by a site which has not been determined to meet applicable requirements of participation.

When an expansion request is received, before making a determination the RO considers the following:

- Whether the proposal meets Medicare statutory and regulatory requirements. For example, in the case of an HHA, does the proposed branch meet the definition of a branch office at 42 CFR 484.2? If it is possible to make a decision based on the provider's description of how it intends to operate, an onsite survey may not be necessary.

- If the proposal complies with State and local laws related to the particular type of provider/supplier; and,

- Whether Medicare reimbursement is affected by the proposal. For example, a hospital states that is has purchased a physicians' clinic that is now a part of the hospital. In such a case, input from the Division of Medicare and the fiscal intermediary will likely be necessary. While HCFA does not dictate to a provider how it should operate its business, the provider does have to comply with Medicare requirements. Whenever an entity can meet the requirements of two different categories; e.g., subunit and independent home health agency, it is generally HCFA's policy to designate the category for which there is the least potential to increase Medicare costs. If a proposed branch is in an area that would receive a different payment rate than the parent HHA, it could be found to be in a different geographic area and determined not to be a branch.

Although legal authority exists for conducting a survey, a survey may not be necessary because the provider furnishes the RO with sufficient information to make a determination about its proposed expansion either at the time of its initial request or subsequently. If the RO believes a survey is required, but the SA is unable to conduct a survey within a reasonable period of time, the RO may take one of the following actions:

- Make a determination based on the expansion information provided by the provider and inform the provider of the decision; and

- Inform the provider that a survey will be necessary and that it should not bill Medicare for services provided at the proposed expansion location until the survey is conducted and a determination is made.

In the absense of notification of an expansion, HCFA has the authority to deny bills for services furnished at the expanded site. When notification is received of a proposed expansion, the RO should inform the provider of whether the expanded site meets applicable requirements. The fiscal intermediary should be notified of the RO's decision.